Printed: 12/21/2017 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01		(X3) OATE SURVEY COMPLETED	
		495188		B. WING _		12/2	1/2017
	ROVIDER OR SUPPLIER ATTOX HEALTH AN	D REHABILITATON	235 EV	RESS, CITY, S ERGREEN IATTOX, V			
(X4) IO PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT Surveyor: 34730	rs	in the second transcenter constant	K 000			
	Construction Type: Number of stories: Building description	One Story : The facility is a one	e-slory		Appomattox Health and Rehibilitation	п	
	Building description: The facility is a one-slory building of wood frame construction with concret floors, and is separated from the two-story building by a 2-hour rated barrier wall.				The facility desires that the Plan of (be considered the facility's allegation compliance,	Correction n of	
	Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by a 30,000 gallon static water tank and a diesel fire pump.				The statements made in this POC a admission and do not constitute agrainth the alleged deficiencies here in Completion Date 1/26/2018	eement	
	Safety Code survey accordance with 42 Part 483: Requirem Facilities. The facilities compliance using the regulations. The fac	andard recertification was conducted 12/2 Code of Federal Re ents for Long Term (ity was surveyed for the LSC 2012 Existing cility was not in comp nts for Participation I	21/f7 in gulation, Care				
	The lindings that fol non-compliance with Regulations, 483.70 Fire.)		ty from				
K 16 f	NFPA 10 f Building (Construction Type ar	nd Height	K 161			
		n type and storles m ss otherwise permitte					
1.4000476	, ,	OEDELIDBUED DEBDECE	174711600010	WATURE			<u> </u>

Any deliciting statement ending with an asterisk (*) denotes a deticiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above lindings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deticlencies are clied, an approved plan of correction is requisite to continued program participation.

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) OATE SURVEY COMPLETED	
		495188		B. WING _		12/21	1/2017
NAME OF F	ROVIOER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
APPOM	ATTOX HEALTH AN	D REHABILITATON	235 EV	ERGREEN	AVE		
				IATTOX, V			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCE	s i	lo	PROVIDER'S PLAN OF CORRE	CTION	(XSI
PREFIX TAG	EACH OFFICIENCY MUST			PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APP OEFICIENCY)	DULD BE	(XS) COMPLETION OATE
K 161	Continued From pa	age 1		K 161			
	Constructio 1 I (442), I (3: slories	n Type 32), il (222) Any nu	mber of				
	sprinklered	non-sprinklered and	d				
	2 II (111) non-sprinklered	One story					
	sprinklered	Maximum 3 stories					
	3 II (000) non-sprinklered	Not allowed					
	4 III (211) sprinklered 5 IV (2HH)	Maximum 2 sto	ries				
	6 V (111)						
	7 III (200) non-sprinklered	Not allowed					
	8 V (000) sprinklered	Maximum 1 sto	rry				
		must be sprinklered					
		eproved, supervised ce with section 9.7. (
	Give a brief descrip	tion, in REMARKS, o					
	basements, floors o	n which patients are	located,				
	locallon of smoke or fire barriers and dates of						
	approval. Complete sketch or attach small floor						
	plan of the building as appropriate. This Standard is not met as evidenced by:						
	Surveyor: 34730		ωy.				
	Based on observation and inspection it was		was				
	determined that the	facility failed to malr	ntain				
	bullding construction	n. This has the ability	y to affect				
	all occupants of the	building.					

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION (XI) PROVIOER/SUPPLIER/CLIA (X3) OATE SURVEY IOENTIFICATION NUMBER: A. BUILOING 01 - MAIN BUILDING 01 COMPLETEO 495188 B. WING_ 12/21/2017 STREET ADORESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATION 235 EVERGREEN AVE APPOMATTOX, VA 24522 SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION) (X4) IO PREFIX TAG (X5) COMPLETION OATE IO PREFIX PROVIDER'S PLAN OF CORRECTION TEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE TAG **OEFICIENCY**) K 161 Continued From page 2 K 161 Findings Include: 1. On 12/20/2017 the cross corridor smoke doors were adjusted to maintain smoke tight. On 12-21-17 at approximately 10:28 am it was observed through observation and inspection that On 12/21/2017 caulking added to eliminate any the cross corridor smoke doors by the Main unprotected penetration in the attic smoke barrier Entrance are not being maintained smoke tight. above the Zone 3 doors. Contacted Fire Contractor 12/26/2017 to repair/replace On 12-21-17 at approximately 11:24 am it was attic access door to maintain self closing and latching. observed through observation and inspection that there is an unprotected penetration in the Attic 2. Maintenance Oirector to review monthly smoke smoke barrier above the Zone 3 doors. doors, any unprotected penetrations in smoke barriers and the altic access door for proper closura and latching, On 12-21-17 at approximately 11:30 am it was 3. Maintenance Director will verify quarterly to observed through observation and inspection that ensure compliance. (Smoke doors maintain smoke tight, no unprotected penetrations in the attic smoke the rated Attic access door is not being parrier, and the attle access door properly closes maintained self closing and latching. and laiches.) The Facility Maintenance Director and 4. Each process will be reviewed in QA for two quarters Administrator witnessed this evidence by 5. Completion 1/26/2018 observation and Interview. K 345 NFPA 101 Fire Alarm System - Testing and K 345 Maintenance 1. On 12/21/2017 (2) heat detectors were reattached to the mounting bracket. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in 2. Maintenance Director will review monthly and realtach as needed. accordance with an approved program complying with the requirements of NFPA 70, National 3. Maintenance Director will review any heat detectors Electric Code, and NFPA 72, National Fire Alarm quarterly to ensure compliance of all heat detectors and Signaling Code. Records of system attached as required. acceptance, maintenance and testing are readily 4. Process will be reviewed in QA for two quarters. avallable. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 5. Comptetion 12/21/2017. This Standard is not met as evidenced by: Surveyor: 34730 Based on observation and inspection it was determined that the facility failed to maintain the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		495188		B. WING		12/21	/2017
	ROVIDER OR SUPPLIER				STATE, ZIP CODE	<u> </u>	
APPOMA	ATTOX HEALTH AN	D REHABILITATON		ERGREEN IATTOX, V			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PŘEFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLO BE	IX5) COMPLETION DATE
	occupants of the but Findings include: On 12-21-17 at app observed through o 2 heat detectors in a mounted to the mounted to the Facility Mainter	This has the ability to ilding. roximately 11:24 am bservation and inspetthe Attle are not secunting bracket. nance Director and ssed this evidence by erview.	It was ection that orely	K 345			
	Electrical Systems List in the REMARK Chapter 6 Electrical are not addressed to are deficient. This in applicable Life Safe citation, should be in Chapter 6 (NFPA 98 This Standard is no Surveyor: 34730 Based on observatil determined that the electrical system. The occupants of the but Findings include: On 12-21-17 at app observed through of there is an open jun above the Zone 3 de The Facility Mainter	Other S section any NFPA Systems requireme by the provided K-Tag formation, along wit ty Code or NFPA stancluded on Form CM b) of met as evidenced if the facility failed to main his has the ability to a bidding. Toximately 10:40 am biservation and inspection box above the bors. Tance Director and bised this evidence by	nts that gs, but h the indard is-2567. by: was hain the affect all it was ection that celling		1. On 12/21/2017 Device was reattached Box. 2. Maintenance Director to review monthly repairs as needed. 3. Maintenance Director to review and ver to ensure compliance that no functions both. Process will be reviewed in QA for two states. Completion 12/21/2017.	r and make ify quarterly xes are open	

STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA NO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA			1 '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) OATE SURVEY COMPLETEO		
		495188	_	B. WING _		12/21	/2017
	ROVIOER OR SUPPLIER				STATE, ZIP CODE		`
APPOMA	AITOX HEALIH AN	D REHABILITATON		'ERGREEN MATTOX, V			
(X4) IO		ATEMENT OF OEFICIENCIES BE PRECEOEO BY FULL I	s	10	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG		INTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRI OEFICIENCY)		DATE
	Continued From pa			K 918			
K 918	NFPA 101 Electrical Systems - Essential Electric Syste			K 918			
	Electrical Systems - Essential Electric System				On 12/26/2017 Electrical contractor revelectrical system.	iewed lhe	
	Maintenance and To The generator or ot	her alternate power:	source		Annual main and feeder circuit breaker so inspection on or before 1/26/2018.	heduled for	
		Ipment is capable of econds. If the 10-sec			Maintenance Director to establish a PN compliance with testing and exercising bring and exercising bring the second compliance.		
	process shall be pro	during the monthly te ovided to annually co	onfirm this		3. Maintenance Director to review and verify monthly to		
	Maintenance and te	e safety and critical besting of the generate	or and		ensure compliance. 4. Process will be reviewed in QA for two	nuarters	
	transfer switches ar with NFPA 110.	re performed in acco	rdance		5. Completion 1/26/2018.	qualitoro.	
		Inspected weekly, extes 12 times a year l					
	day intervals, and e	xercised once every uous hours. Schedu	36				
	under load condition	ns include a complet	e				
		and automatic or moads, and are condu					
	competent personn	el. Maintenance and	testing of			:	
		er sources (Type 3 El PA 111. Maln and fe					
***	circult breakers are program for periodic	inspected annually,	and a				
		blished according to					
	manufacturer requir	rements. Written red	ords of				
		sting are maintained					
•		ES electrical panels and readily identifial					
		sibility of damage of t					
	emergency power s	ource is a design					
	consideration for ne						
	111, 700.10 (NFPA)						
	This Standard is no Surveyor: 34730	ot met as evidenced	by:				
	Based on observati	on and inspection it v facility falled to main					

		1	, 4 – 4	7		CIVIO IVO.	0930-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIE IOENTIFICATION NU!		i	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) OATE SU COMPLE	
		495188		e. WING_		12/21	/2017
NAME OF P	ROVIOER OR SUPPLIER		STREET ADO	RESS, CITY.	STATE, ZIP COOE		
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K 918	Continued From pa	are 5		K 918			
10			-14 -4 11	1/ 910			
		his has the ability to	alfect all				
	occupants of the bu	Jilding.	į				
			}				
	Findings include:		ļ				
		proximately 10:00 am					
		bservation and inspe					
	documentation cou	ld not be provided to	show that				
	the main and feede	r circuit breakers are	·				
	inspected annually,	and a program for p	eriodically				
	exercising the comp	ponents Is establishe	d				
		acturer regulrements					
		ance and testing are					
	maintained and rea	dily avallable.					
			į				
	The Facility Mainter	nance Director and					
		ssed this evidence b	v l				
	observation and Into		'				
K 919	NFPA 101 Electrica	l Equipment - Other		K 919			
			1		1. On 12/20/2017 The power strip was plu	goed directly	
	Electrical Equipmer		-		into a permanently installed receptacle.		
		(S section any NFPA					
		al Equipment, requir			2. Mainlenance Director in-serviced depar slaff regarding the use of power strips. 12/	meni head	
	that are not address	sed by the provided I	K-Tags,		were tageroung the east of pomer strips. 12/	FILEGIL	
		is information, along			3. Maintenance to review monthly to verify	and ensure	•
		ty Code or NFPA sta			compliance.		
	citation, should be i	ncluded on Form CN	1S-2567.		4. Process will be reviewed in QA for two	uariers.	j
	Chapter 10 (NFPA 9		-			1	
		ot met as evidenced	by:		5. Completion 12/20/2017.		
	Surveyor: 34730						
		on and Inspection it					
		facility falled to mair					
		t. This has the ability	to affect				
	all occupants of the	bullding.					
	Findings include:						
	On 12-21-17 at app	roximately 10:25 am	it was				
		bservation and inspe					
		plugged directly into					

Printed: 12/21/2017 FORM APPROVED

CENTER	IS FOR MEDICARE	& MEDICAID SERV	CES			OMB NO.	0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA MBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		495188		B. WING_		12/21	1/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE				
APPOM/	ATTOX HEALTH AN	D REHABILITATON	235 EV	ERGREEN AVE				
				ATTOX, \				
	5				77 E10EE			
(X4) ID		ATEMENT OF DEFICIENCIE		۵۱	PROVIDER'S PLAN OF CORRECT		(XS) COMPLETION	
	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL F	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETION DATE	
TAG	On Lag lug	INTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO	OPRIATE 1	DATE:	
					DEFICIENCY)			
K 919	Continued From pa	age 6		K 919				
			-ip			,		
	permanently installed receptacle in the HR Office On 12-21-17 at approximately 10:26 am it was observed through observation and inspection that a hair dryer in the Beauty Shop has a damaged power cord and is in use.							
					1. Hair Dryer power plug replaced 12/27/2017.			
					2. Maintenence Director to relvew monthly for any damaged cords and replace as ner	power plugs eded.		
					3. Maintenance to verify power cords mon	lhiy to ensure		
					compilance. 4. Process will be reviewed in QA for two quarters.		***************************************	
	The Facility Mainter	nance Director and						
	The Facility Maintenance Director and Administrator witnessed this evidence by observation and interview.				5. Completion 12/27/2017.		***************************************	
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and the second								
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	STATEMENT DF OEFICIENCIES IX1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02		(X3) OATE SURVEY COMPLETEO	
		495188		B. WING_		12/21/2017	
	ROVIDER OR SUPPLIER ATTOX HEALTH AN	D REHABILITATON	235 EV	RESS, CITY, S ERGREEN IATTOX, V			
(X4) IO PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF OEFICIENCIE I BE PRECEDED BY FULL F INTIFYING INFORMATION)		IO PREFIX TAG	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO OEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs		K 000			
	Surveyor: 34730 Construction Type:	II(111)					
:	Number of stories:	Two Stories					
Building description: The facility is a two-story building separated from the one-story main building by a 2-hour rated barrler wall. The first floor contains the dining area, kitchen, and Physical Therapy Gym. The basement contains the mechanical room and laundry facility. There are no sleeping areas in this building.							
	Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by a 30,000 gallon static water tank and a diesel fire pump.						
	Safety Code survey accordance with 42 Part 483: Requirem Facilities. The facil compliance using the regulations. The fa	andard recertification was conducted 12/2 Code of Federal Re- lents for Long Term (ity was surveyed for ne LSC 2012 Existing cility was not in comp nts for Participation I	21/17 in gulation, Care		÷		
	Fire.)	h Title 42 Code of 0(a) et seq (Life Safe	ty from				
K 324	NFPA 101 Cooking	Facilities		K 324			
	with NFPA 96, Stan	is protected in accordance for Ventilation C	ontrof		1. Kitchen Hood Vents were cleaned of 12/27/2017.		
LABORATOR	Y OHECTOR'S OF PROV	PERISUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	N / TITLE		(X6) DATE

Any delidiency statement ending with an asterisk (*) denotes a deliciency which the institution may be excused from correcting providing it is determined that other safebuards provide sufficient protection to the pattents. (See instructions.) Except for nursing homes, the lindings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above lindings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deliciencies are clied, an approved plan of correction is requisite to continued program participation.

	STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02		(X3) OATE SURVEY COMPLETED	
		495188		e, WING_	minus de la companya	12 /21	/2017
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
APPOMA	ALIOX HEALIH AN	D REHABILITATON		ERGREEN IATTOX, V			
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	Operations, unless: * residential cooking appliances such as toasters) are used fooking in accordar * cooking in accordar * cooking facilities of compartments with with the conditions of or ewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities proper 9.2.3 are not rechazardous areas, by corridor. 18.3.2.5.1 (hrough 19.3.2.5.5, 9.2.3, The cooking facilities proper 9.2.3 are not rechazardous areas, by corridor. 18.3.2.5.1 (hrough 19.3.2.5.5, 9.2.3, The cooking equipment of the cooking equipment of the findings include: On 12-21-17 at approbserved through of	of Commerciat Cooking equipment (I.e., sm microwaves, hot plater food warming or lince with 18.3.2.5.2, 19 ppen to the corridor in 30 or fewer patients under 18.3.2.5.3, 19. In smoke compartmes comply with condition 4. In the compartment of the comply with condition 4. In the compartment of the comply with condition 4. In the compartment of the comply with condition 4. In the compartment of the comply with condition 4. In the compartment of the comply with condition 4. In the compartment of the compart	hall htes, lmited 19.3.2.5.2 n smoke comply 3.2.5.3, hts with ons under NFPA 96 d as to the I through by: was htain to affect it was ection that	K 324	2. Maintenance Director to review/cle and other times as needed. 3. Maintenance Director and Dining S Manager to verify monthly to ensure of the completion 12/27/2017. 5. Completion 12/27/2017.	ervices compliance.	
	The Facility Mainten Administrator witnes	nance Director and ssed this evidence by	у				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02		(X3) DATE SURVEY COMPLETED	
		495188		e, wing_		12/21	/2017	
	PROVIDER OR SUPPLIER		5	RESS, CITY, 9	STATE, ZIP CODE	···.		
APPOM	ATTOX HEALTH AN	D REHABILITATON		ERGREEN IAITOX, V				
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	' OE PRECEDED OY FULL I	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT JEACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(XS) COMPLETION OATE	
K 324				K 324				
K 741	NFPA 101 Smoking	Regulations		K 741				
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 6E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 24 Continued From page 2 observation and interview. 31 NFPA 101 Smoking Regulations Smoking Regulations Shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptled shall be readily available to ali areas where smoking is permitted. 18.7.4, 19.7.4 This Standard is not met as evidenced by: Surveyor: 34730 Based on observation and inspection it was determined that the facility failed to maintain smoking reguiations. This has the ability to affect all occupants of the building. Findings include:			1. Non-Approved Smoking Area clear 12/28/2017 of clgarette butts. 2. Staff in-service scheduled to review smoking area 12/28/2017. 3. MaIntenance Director to review/cle and other times as needed to ensure provided. 4. Process will be reviewed in QA for 5. Completion 12/28/2017.	v designated an monihly compliance			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02		(X3) OATE SURVEY COMPLETEO	
		495188		B. WING		12/21	1/2017
NAME OF P	ROVIOER OR SUPPLIER		STREET AOD	RESS, CITY,	STATE, ZIP CODE	L	
APPOMA	ATTOX HEALTH AN	D REHABILITATON		ERGREEN MATTOX, V		•	
(X4) ID PREFIX TAG	ĮEACH OEFICIENCY MUST	ATEMENT OF OEFICIENCIE TOE PRECEDEO BY FULL F INTIFYING INFORMATION)		IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEF(CIENCY)	ILO BE	(X5) COMPLETION OATE
K 741	clgarettes are being area not approved b regulations. The Facility Mainter	bservation and inspe g improperly disposed by the facilities smok nance Director and ssed this evidence by	d of in an ing	K 741			
K 918	Electrical Systems Maintenance and To The generator or ot and associated equivaries within 10 secriterion is not met of process shall be process and lettransfer switches are under load 30 minuted load 30 minuted load conditions in the shall be processed and shall be s	ther alternate power spipment is capable of conds. If the 10-sect during the monthly lest ovided to annually consisted annually consisted weekly, extended to the conduction of the generator of	ystem source supplying ond est, a onfirm this ranches. or and rdance kercised n 20-40 36 led test e anual leted by testing of ES) are In eeder and a	K 918	1. On 12/26/2017 Electrical contractor the electrical system. Annual main and feeder circuit breake for inspection on or before 1/26/2018. 2. Maintenance Director to establish a ensure compliance with testing and exbreakers. 3. Maintenance Director to review and monthly to ensure compliance. 4. Process will be reviewed in QA for the 5. Completion 1/26/2018.	er scheduled PM to kercising	
	under load 30 minuday Intervals, and emonths for 4 continuated cold start transfer of all EES Incompetent personnestored energy power accordance with NF circuit breakers are program for periodic components is estamanufacturer requirmaintenance and te readily available. Ecircuits are marked	tes 12 times a year in xercised once every uous hours. Schedul institute a complete and automatic or maio oads, and are conduled. Maintenance and insources (Type 3 Ele FPA 111. Main and fer inspected annually, cally exercising the blished according to rements. Written recording	n 20-40 36 led test e anual letted by testing of ES) are In eeder and a cords of and and ole.			wo quarters	

DEPARTMENT	OF HEALTH AT	NAMUH DI	SERVICES
CENTERS FOR	NEDICARE &	MEDICAID	SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G 02 - MAIN BUILDING 02	(X3) DATE SURVEY COMPLETED	
		495188		B. WING_	MANUAL MA	12/2	1/2017
	PROVIDER OR SUPPLIER ATTOX HEALTH AN	D REHABILITATON	235 EV	RESS, CITY, I ERGREEN IATTOX, V			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE GE PRECEOED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	IX5) COMPLETION DATE
K 918	emergency power's consideration for ne 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This Standard is not Surveyor: 34730 Based on observati determined that the electrical system. To occupants of the but Findings include: On 12-21-17 at approbserved through of documentation could the main and feede inspected annually, exercising the compaccording to manufaccords of maintenamaintained and rear The Facility Mainter	cource Is a design aw Installations. NFPA 99), NFPA 110 70) of met as evidenced on and inspection II villations. It is a state ability to a servation and inspection and a program for proponents is established acturer requirements ance and testing are dily available.	by: was ntain the affect all it was ection the show that eriodically d . Written	K 918			

PART IV - FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS 2786 FORMS)

2W- 1648-001

Provider Number	Facility Name		Survey Date
49-5188	Appomattox Health &	Dehah	12-21-17
K1 43-3100	Appointation Fleatin &		*K4
K6 DATE OF PLA APPROVAL 06-1988	TOTAL NUMBER OF	00	C. FLOOR
LOO FORM NIDIO	NUMBER OF THIS BI	OILDING	_ D. APARTMENT UNIT
LSC FORM INDICA	IOR	COI	MPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, ISTING
	ALTH CARE FORM	SM	MALL (46 DEDG OD LEGG)
12 2786R	2012 EXISTING	SIVI.	IALL (16 BEDS OR LESS)
13 2786R	2012 NEW	К8	1. PROMPT 2. SLOW 3. IMPRACTICAL
	AHCO FORM	LAF	RGE
14 2786U	2012 EXISTING		
15 2786U	2012 NEW] кв	4. PROMPT 5. SLOW 6. IMPRACTICAL
	ICF/IID FORM	1 —	
16 2786V,	W, X 2012 EXISTING	- AP/	ARTMENT HOUSE
17 2786V,	W, X 2012 NEW	кв	7. PROMPT 8. SLOW 9. IMPRACTICAL
*K7 12 SELECT N	IUMBER OF FORM USED FR	OM ABOVE	9. IIVIPRACTICAL
(Check if K321 or K	351 are marked as not applical	ble EXIS	MPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, ISTING
in the 2786 M, R, T,	U, V, W, X, and Y.)	ENT	TERE-SCORE
К321:	K351:		K5: e.g. 2.5
*K9 FACILITY M	EETS LSC BASED ON (Chec	k all that Apply)	
A1.	A2.	A3.	A4. A5.
(COMP. WITH PROVISION		POC) (WAI	IVERS) (FSES) (PERFORMANCE BASED DESIGN)
FACILITY DOES NO	OT MEET LSC K0180	·	
*MANDATORY	POLLI	A. SPRINKLERED required areas are sprinklered)	B. C. PARTIALLY SPRINKLERED NONE (Not all required areas are sprinklered) (No sprinkler system)

PART IV - FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS 2786 FORMS)

W- 1648-001

			(10 BE 03	ED WITH C	WS 2/86 FU	rkivis)	VV- 1648-001
Prov	ider N	lumber	Facility Name			Survey Date	
_K1		49-5188	Appomattox Health 8	Rehab		*K4	12-21-17
K6	APPF	E OF PLAN ROVAL	K3 MULTIPLE C TOTAL NUMBER OF	ONSTRUCTIONS	A	A. BUILDING B. WING	}
	0	6-1988	7 0 11 12 11 0 11 0 2 1 (0)	DOILDINGO,		C. FLOOR	
		-	NUMBER OF THIS E	BUILDING	01 ———	D. APARTME	ENT UNIT
LSC	FOR	VI INDICATOR			COMPLETE IF	ICF/IID IS SURVEY	ED UNDER CHAPTER 33,
		HEALTH	CARE FORM	7	EXISTING		
	12	2786R	2012 EXISTING	1	SMALL (1	16 BEDS OR LES	S)
	13	2786R	2012 NEW		 K8	1. PROM 2. SLOW	1
				7	_	3. IMPR	ACTICAL
	14		O FORM		LARGE		
	14	2786U	2012 EXISTING			→ 4. PROM	IDT
	15	2786U	2012 NEW		K8	5. SLOW	
				- -		☐ 6. IMPR/	ACTICAL
			D FORM		APARTMENT	HOUSE	
	16	2786V, W, X	2012 EXISTING				IDT
	17	2786V, W, X	2012 NEW		к8	7. PROM 8. SLOW 9. IMPRA	
						5. IVII 177	TOTIOAL
*K7	12 5	SELECT NUMB	ER OF FORM USED FF	ROM ABOVE			
					COMPLETE IE	ICE/IID IS SUBVEY	'ED UNDER CHAPTER 33,
(Che	ck if K	(321 <mark>o</mark> r K351 ar	e marked as not applica	ble	EXISTING	ICF/IID IS SURVE	ED UNDER CHAPTER 33,
in the	e 2786	6 M, R, T, U, V,	W, X, and Y.)		ENTER E - S	CORE	
		K321:	V254.		Г		
		K321.	K351:		K5:	e.g. 2.5	
*K9	FA	CILITY MEETS	LSC BASED ON (Che	ck all that App	ly)		
	A1	1.	A2.	A3	B. 🔲	A4.	A5.
		MP. WITH ALL ROVISIONS)	(ACCEPTABLE	POC)	(WAIVERS)	(FSES)	(PERFORMANCE
FAC		DOES NOT ME	ET LSC K0180				BASED DESIGN)
		В.	FULL	A. V Y SPRINKLEF required areas ar sprinklered)		LLY SPRINKLERI all required areas are sprinklered)	C. NONE (No sprinkler system)
*MAI	NDAT	ORY					

Form CMS-2786R (10/2016)

2012 LIFE SAFETY CODE

Form Approved OMB Exempt

W-1648-001

FIRE SAFETY SURVEY REPORT 2012 CO	EY REPORT 2012 COL Medicare – Medicaid	ODE – HEALTH CARE d	:	1. (A) PROVIDER NUMBER 49-5188		1. (B) MEDICAID I.D. NO.	49-51883
OPTIONAL —	PA Chapter 4 – NFPA 1	PART I — Life Safety Code, New and Existing PART II — Health Care Facilities Code, New and Existing PART III — Recommendation for Waiver PART III — Crucial Data Extract OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T	— Life Safety Code, New and E ealth Care Facilities Code, New IT III — Recommendation for W PART IV — Crucial Data Extract Safety Evaluation System for H	and Existing Pow and Exister For Waiver Stract for Health Car	ting e Occupancies -	- CMS-2786T	
Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change	plicable records. Ente	er changes, if any, alon	igside each île	em, giving date	of change.		
2. NAME OF FACILITY Appomattox Health & Rehab Building #1 Main Admin: Cynthia Smith	2. (A) MULTIPLE CONS A. BUILDING B. WING C. FLOOR	TRUCTION (BLDGS)	2. (B) ADDRESS OF FACILIT 235 Evergreen Ave. Appomaftox, VA 24522	s OF FACILITY (STI en Ave. VA 24522	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 235 Evergreen Ave. Appomattox, VA 24522	4 8 0	A. [7] Fully Sprinklered All required areas are sprinklered) B. [7] Partially Sprinklered INd all required areas are sprinklered) C. [7] None INo sprinkler system)
	22					K0180	
3. SURVEY FOR ☑ MEDICARE ☑ MEDICAID	4. DATE OF SURVE	2-21-17	DATE OF PLAN APPROVAL 06-1988 K6	N APPROVAL 06-1988	SURVEY UNDER 5. 7 2012 EXISTING x7	ING 6. 🔲 2012 NEW	IEW
5. SURVEY FOR CERTIFICATION OF							
1. 🗌 HOSPITAL 2. 🔽 SKILLED/I	2. 🗹 SKILLED/NURSING FACILITY	4. 🔲 ICF/IID UNDER HEALTH CARE	ER HEALTH CA		5. 🔲 HOSPICE		
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) 1. ☑ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY)		BELOW		3. T IF DISTINC	TINCT PART OF HOSPIT YES b. \(\bigcup \) NO	IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? a. \(\begin{align*} \blue{1} \text{YES} & b. \(\begin{align*} \blue{1} \text{NO} \end{align*}	KEDITED?
6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY 60 CERTIFIED	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	C. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	09	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	(ILLED BEDS MEDICAID 60	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID	SF/IID BEDS
7. A. 🖸 THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)	RD, BASED UPON (CHE	CK ALL APPROPRIATE BC)XES)				
1. COMPLIANCE WITH ALL PROVISIONS 2. A ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. PSES 5.	VISIONS 2. 🔽 ACCEPT	ANCE OF A PLAN OF COR	RECTION 3.	RECOMMENDED	WAIVERS 4 . 🔲 F	SES 5. 🔲 PERFORMA	PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE STANDARD K9	IE STANDARD						
SURVEXOR (Signature) B Barro	TITLE Deputy Star	TITLE Debuty State Fire Marshal	OFFICE	OFFICE SFMO - Region 6	i :	DATE	
SURVEYOR ID 34730			<u>;</u>			12-22-17	
FIRE AUTHORITY DEFICIAL (Signatural) TITLE Chief Deputy State Fire A	TITLE Chief	TITLE Chief Deputy State Fire Marshal	shal OFFICE	SFMO- Region 6	9 1	DATE 12-22-17	
CIMS FORIMS SHALL BE COMPLETED AND RE	EIAINED AS PART OF L	HE SURVEY RECORD.					

(

2012 LIFE SAFETY CODE

Form Approved OMB Exempt

W-1648-002

FIRE SAFETY S	URVEY REPOI	RT 2012 COD	FIRE SAFETY SURVEY REPORT 2012 CODE - HEALTH CARE		1. (A) PROVIDER NUMBER		1. (B) MEDICAID I.D. NO.	
	Medicare	Medicare - Medicaid			49-5188	22	49	49-51883
J	OPTIONAL — Cha	PAI	PART I — Life Safety Code, New and Existing PART II — Health Care Facilities Code, New and Existing PART III — Recommendation for Waiver PART III — Recommendation for Waiver PART IV — Crucial Data Extract OPTIONAL — Chapter 4 — NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies — CMS-2786T	— Life Safety Code, New and Eealth Care Facilities Code, New RT III — Recommendation for WPART IV — Crucial Data Extract Safety Evaluation System for H	and Existing New and Exist for Waiver ctract for Health Care	ing • Occupancies –	- CMS-2786T	
Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.	s shown in applical	ble records. Enter	r changes, if any, alon	gside each ite	m, giving date o	of change.	77,78	
2. NAME OF FACILITY Appomattox Health & Rehab Building #2 Dining Services Admin: Cynthia Smith		2. (A) MULTIPLE CONS A. BUILDING B. WING C. FLOOR	TRUCTION (BLDGS)	2. (B) ADDRESS OF FACILIT 235 Evergreen Ave. Appomattox, VA 24522	OF FACILITY (STF n Ave. VA 24522	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 235 Evergreen Ave. Appomattox, VA 24522	4 8 0 8	Fully Sprinklered (All required areas are sprinklered) Partially Sprinklered (Not all required areas are sprinklered) None (No sprinkler system)
3. SURVEY FOR	4	4. DATE OF SURVEY		DATE OF PLAN APPROVAL	APPROVAL	SURVEY UNDER		
✓ MEDICARE	✓ MEDICAID	4	2-21-17	-90 &	06-1988	5. 🗾 2012 EXISTING	NG 6. 🔲 2012 NEW	
5. SURVEY FOR CERTIFICATION OF	TION OF				E			
1. 🔲 HOSPITAL	2. 🛭 SKILLED/NURSING FACILITY	SING FACILITY	4. 🔲 ICF/IID UNDER HEALTH CARE	ER HEALTH CAF		5. 🔲 HOSPICE		
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) 1. ☑ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY)	KED, CHECK APPROP 2. □ DISTINCT PART	PRIATE ITEM(S) BELOW (T OF (SPECIFY)	MO:		3. T IF DISTING	INCT PART OF HOS	IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? 1. TYES 1. NO	
6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE		6. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	0	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	ILLED BEDS MEDICAID 0	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID	BEDS
7. A. 🖸 THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)	TS THE STANDARD, E	BASED UPON (CHE(CK ALL APPROPRIATE BO	XES)				
1. 🔲 COMPLIANCE	EWITH ALL PROVISIO	NS 2. 🔼 ACCEPTA	ANCE OF A PLAN OF COR!	RECTION 3.	RECOMMENDED	WAIVERS 4 . 🔲 F	1. TO COMPLIANCE WITH ALL PROVISIONS 2. 🖸 ACCEPTANCE OF A PLAN OF CORRECTION 3. TO RECOMMENDED WAIVERS 4. TO FSES 5. TO PERFORMANCE BASED DESIGN	SASED DESIGN
B. THE FACILITY DOES NOT MEET THE STANDARD	S NOT MEET THE ST.	TANDARD						
SURVEYOR (Signature) A. SURVEYOR ID 34730	Baro	TITLE Deputy State	ттLE Deputy State Fire Marshal	OFFICE SFMO -	OFFICE SFMO - Region 6		DATE 12-22-17	
FIRE AUTHORITY OFFICIAL (Synatory Line And Fire North State Fire Now FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.	Mail Constitution of the PLETED AND RETAIN	TITLE Chief I	ef Deputy State Fire Marshal THE SURVEY RECORD.	OFFICE	SFMO- Region 6	9	DATE 12-22-17	